MEDICAL EVALUATORS
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Notice of Independent Review Decision

DATE OF REVIEW: **October 1, 2015**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Denial of coverage for individual psychotherapy 1 times per week for 6 weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
This case was reviewed by a board certified Psychologist who is currently licensed and practicing in the state of Texas.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

EMPLOYEE CLINICAL HISTORY [SUMMARY]:
The claimant is a female who injured her lower back on xx/xx/xx when she was xxxxxxx. She fell onto the floor and twisted her lower back. The claimant has been treated with conservative care including physical therapy and medications (Naproxen and Metaxalone).

On xxxxxx, the claimant had an and reported pain in the lower back, which she described as constant, throbbing, achy, and tender. The claimant reported these symptoms had a negative impact on a wide range of life functions including personal, family, social, occupational activities, and when asked to quantify the level of interference pain had on recreational, social, and familial activities, she rated overall as 9/10, for pain interference with normal activities was 8/10 and change in ability to work was 9/10. The claimant reported difficulties with the following activities of daily living since the injury: Self-grooming, self-care, performing household chores and yard work, cooking, exercising, driving for more than 20 minutes, sitting for more than 20 minutes, standing for more than 20 minutes, walking for more than 15 minutes, bending, squatting, climbing stairs, lifting and carrying objects, and engaging in sexual activity. The claimant explained that difficulties noted were both difficult and painful to go places with or play with her children. The claimant rated that the level of overall functioning in life prior to the injury was 100% and rated the current level of functioning at 25%. The claimant described unwanted

changes in relationships as follows: less participation in social outings and family activities, isolating from others because the claimant felt more irritable due to the pain; feeling abandoned by co-workers and feeling lonely. The claimant also described unwanted changes in self-perception -including a loss of selfconfidence, feeling like a burden, and feeling a lack of control in life. The claimant also reported difficulty falling asleep with 4 or more awakenings per night due to pain, and early morning awakening. The claimant also noted a decreased in appetite with a 20 pound decreased in weight since the injury. On mental status exam, the claimant was cooperative throughout the interview and oriented times in person, place, situation, and time. Attention, concentration, psychomotor activity, speech and intellectual functioning were all deemed to be within normal limits. Mood was anxious while the affect was constricted. Memory for both recent and remote events was impaired. Thought process was goal-directed. She did not hallucinate or appear delusional and did not present with any current risk factors. The claimant scored 8 on the Beck Depression Inventory-II (BDI-II), indicating minimal depression. The claimant scored 20 on the Beck Anxiety Inventory (BAI) reflecting moderate anxiety. The responses on the fear avoidance beliefs questionnaire(F ABQ) showed significant fear avoidance of work (FABQ-PA=24, cut-off was 13). The claimant was diagnosed with somatic symptoms disorder, with predominant pain, persistent, moderate and unspecified anxiety disorder. The claimant was recommended 6 sessions of individual psychological therapy.

Prior UR dated 08/10/2015 denied the request for coverage for individual psychotherapy 1time per week for 6 based on the claimant has not been given a psychological diagnosis based on her symptoms. The claimant wants to treat her anxiety which is in the moderate to severe range; however, depression scale score is within normal limits. Therefore, medical necessity is not established in accordance with current evidence-based guidelines.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The Official Disability Guidelines (ODG) recommends psychotherapy treatment when a clear diagnosis of depressive disorder is diagnosed and documented. According to medical records reviewed, the claimant has not received any diagnosis consistent with mental illness; therefore, the criteria for psychotherapy treatment has not been established according to ODG. Based on the ODG and the clinical documentation stated above, it is my clinical opinion that the request for individual psychotherapy once a week for 6 weeks is deemed not medically necessary, and I am recommending to uphold previous reviews of adverse determination.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

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Mental Illness & Stress - (updated 08/31/15) – Online Version
Cognitive therapy for depression
ODG Psychotherapy Guidelines:
- Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made. (The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.)
- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made.

Major depressive disorder, diagnosis
Recommend using the protocol provided in the American Psychiatric Association's diagnostic manual as the essential core of the diagnostic evaluation. (American Psychiatric Association, 2000) The diagnostician should compare the claimant's presentation to all of the information in that protocol, including diagnostic features, associated features and disorders, course, and differential diagnosis. The following examples of issues from that protocol are not intended to serve as a substitute for the full protocol. These examples are only being provided in order to give readers some idea of what the protocol involves, and to at least partially convey the complex nature of the protocol. For example, the protocol specifies that MDD is characterized by a history of one or more Major Depressive Episodes, which are phases when the symptoms are present. These episodes are defined as: a period of at least 2 weeks during which there is a depressed mood and/or the loss of interest or pleasure in nearly all activities; the individual also experiences at least four additional symptoms drawn from a list that includes changes in appetite or weight, sleep disturbance, psychomotor agitation (e.g., observable restlessness) or psychomotor retardation (e.g., observably moving more slowly than usual), decreased energy, feelings of worthlessness or guilt, difficulty thinking/ concentrating/ making decisions, recurrent thoughts of death or suicidal ideation/plans/attempts; and the symptoms persist for most of the day, nearly every day, for at least 2 consecutive weeks. The person with this disorder has not experienced any Manic, Mixed, or Hypomanic Episodes, (which would push the diagnosis toward the Bipolar and Cyclothymic disorders, instead of MDD). This mental illness is typically manifested in phases – the person is mentally ill for a period of time, and is then typically free from the symptoms of the mental illness for a period of time, but will probably develop additional episodes of symptoms in the future. Some psychological tests (e.g., Minnesota Multiphasic Personality Inventory, Battery for Health Improvement, Millon Clinical Multiaxial Inventory, Structured Interview of Reported Symptoms) can be used as an important adjunct to the diagnostic process, specifically for the purpose of introducing an objective element to a process that is otherwise completely subjective. (Bruns, 2001) (Butcher, 2004) (Millon, 2001) (Rogers, 1992) In order to enhance the credibility of diagnostic findings, the claimant's history can be thoroughly reviewed. Such a review can ideally involve an examination of records from the claimant's entire life, and collateral reports. This thorough type of approach is preferable to relying on the report of the claimant, because scientific findings have consistently revealed that an examinee's report

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of his or her history is not a credible basis for clinical decision-making. (Barsky, 2002) (Lees-Haley, 1996) (Carragee, 2007) If there is an IME physician in a workers' comp setting, any such evaluation (and associated treatment planning) should take place on an independent basis. (Barth, 2005) If the evaluation does not take place on an independent basis, then the clinician must avoid any discussion regarding forensic issues such as work-relatedness, disability, etc. (Barth, 2005) Mexican immigrants have a significantly higher risk for depression or anxiety disorder compared to nonmigrant family members of migrants in Mexico (odds ratio, 1.42), and this was especially high in the most recent birth cohort (18-25), where the odds ratio was 3.89. (Breslau, 2011)